DIRECT DEPOSIT AUTHORIZATION /AGREEMENT Form

Section C – 4 (Page 1 of 1)

Make one copy of this form for your records and mail original form with a copy of a voided check for the account to**:**

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

☐ New Application ☐ Change Bank Account Information

NOTE: Because of the Federal Cash Management Act, it is necessary for the Division of Medicaid to mandate the Direct Deposit of Medicaid payments to all Medicaid providers. With the weekly average Medicaid provider payments exceeding $20 million, without Direct Deposit the interest to the Federal government would have to be paid from all State funds that would other wise be used to match federal funds to make provider payments. Given Mississippi's favorable federal match rate, this would have the potential of reducing total program dollars by more than $10 million per year. This process has been underway since October 26, 1992 and has proven to be beneficial to both the State of Mississippi and the Medicaid providers. Please complete this form in order for us to complete your enrollment process and begin depositing your funds electronically.

Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number.

Provider Name	***Provider Contact***
Provider Number	***Provider Telephone Number***

Provider's Address (City, State and Zip Code)

Bank Name

Bank Address (City, State and Zip Code)

Bank Account Number

Bank Transit/Routing Number

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents; or concealment of a material fact, may be prosecuted under applicable federal or state laws. I further authorize the Mississippi Medicaid agency to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered.

I further understand that in the event my bank account information were to change, I must notify the Mississippi Medicaid agency in order to change my bank account information immediately. I will not hold the Mississippi Medicaid agency liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.

Provider Signature	***Date***